

SENT VIA EMAIL OR FAX ON
Oct/27/2011

True Decisions Inc.

An Independent Review Organization
2002 Guadalupe St, Ste A PMB 315
Austin, TX 78705
Phone: (512) 879-6332
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/26/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Epidural Steroid Injection @L5/S1; Fluoroscopy, Anesthesia

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

PMR

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Cover sheet and working documents

Utilization review determination dated 09/19/11, 10/03/11

Letter dated 10/10/11

Office visit note dated 07/27/11, 08/24/11, 09/22/11, 01/10/11

MRI lumbar spine dated 12/15/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient slipped and fell. MRI of the lumbar spine dated 12/15/10 revealed at L5-S1 no spondylolysis but there is a 5 mm anterior spondylolisthesis of L5 in relationship to S1 secondary to advanced degenerative facet disease and there is a 4 mm central bulge of the disc with no impression on dura. There is a evidence of a small posterior annular tear. There is slight central stenosis and mild lateral recess stenosis. There is mild neural foraminal stenosis. There is suggested borderline constriction of the left L5 nerve root. The disc is overtly dehydrated and has moderate decrease in height. Note dated 01/10/11 indicates that the patient has obtained physical therapy with some relief. Physical examination on 07/27/11 indicates motor strength is rated as 5/5 in bilateral hip flexion, bilateral knee extension, bilateral knee flexion, bilateral thigh adduction and bilateral thigh abduction; 4/5 bilateral foot inversion, bilateral foot eversion, bilateral dorsiflexion of great toe, bilateral plantar flexion. Deep tendon reflexes are 1+ bilateral knees and 0+ bilateral ankles. There is subjective dysesthetic sensation bilateral L4, L5 and S1.

The initial request for lumbar epidural steroid injection was non-certified on 09/19/11 noting the patient has expansive complaints that are not supported by physical examination findings or MR imaging. There is no corroboration of lumbar radiculopathy by imaging studies. The lumbar MRI shows multilevel spondylosis and a degenerative listhesis at L5-S1 (not unusual for a 63 year old male). The denial was upheld on appeal dated 10/03/11 noting the same rationale as the initial determination.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

Based on the clinical information provided, the request for lumbar epidural steroid injection at L5-S1, fluoroscopy, anesthesia is not recommended as medically necessary, and the two previous denials are upheld. The patient's physical examination fails to establish the presence of active lumbar radiculopathy, and the submitted MRI does not support the diagnosis. The Official Disability Guidelines note that radiculopathy must be present on physical examination and must be corroborated by imaging studies/electrodiagnostic results. Given the current clinical data, the requested epidural steroid injection is not indicated as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)